Autobiographical Intake Form

Date

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Name:		**DOB:**	

Please print off this biographical form to complete it. My website is not confidential to send personal information through the Internet. All information is confidential as outlined in the HIPAA Contract Form. Please sign the Releases for HIPAA Privacy, Insurance and Telepsychology as well. Bring all of these to your first appointment.

NAME			Date
MALE	FEMALE	NON-BINARY	TRANS
DATE OF BIRTH		AGE	
PLACE OF BIRTH			
ADDRESS: Street			
City	State		Zip
TELEPHONE: Cell EMAIL ADDRESS			
HIGHEST GRADE/DEGREE OCCUPATION			
PERSON TO CALL IN EMERGENCY Name			
Relationship		Phone Number	
REFERRAL SOURCE			
PRESENTING PROBLEM (be as specific as you can)			
Estimate the severity of the above problem Mild Moderate Severe Very severe			
Sexual Orientation	Heterosexual	Gay/Lesbian	Bisexual Transgendered
Partner/Marital status Currently live with someone?	Yes	No	
PARTNER/SPOUSE NAME Years Together		Spouse/Partner Date of Birth	
SPOUSE/PARTNER	Education Level		Occupation
PAST & PRESENT PARTNERSHIPS/MARRIAGES			

(years together, names & statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile, physical violence)
CHILDREN/STEP/GRAND (names, ages & brief statement on your relationship with the person)
PARENTS/STEP-PARENT (Name/age occupation, personality, how did s/he treat you, brief statement about the relationship and if appropriate, year of death/cause of death) Father
Mother
Step-Mother
Step-Father
SIBLINGS (names, ages & brief statement about the relationship; if deceased, age and cause of death)
DESCRIBE YOUR CHILDHOOD IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent)
IF PARENTS DIVORCED: Your age at the time, Describe how it affected you at the time:
MEDICAL DOCTORS Name, Phone
PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness)
Specify all MEDICATION you are presently taking and for what.

PAST/PRESENT DRUGand/or ALCOHOL USE or ABUSE (AA, NA, treatments)

SUICIDE ATTEMPT/S or VIOLENT BEHAVIOR (describe: ages, reasons, circumstances, how, etc)

FAMILY HISTORY OF ALCOHOLISM, METAL ILLNESS, OR VIOLENCE
(including suicide, depression, hospitalizations in mental institutions, abuse, etc.)

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: cancer, epilepsy, etc)

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.)

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning, end), estimated no. of sessions, name, initial reason for therapy, Ind/Couple/Family, medication, and how helpful it was, and how/why it ended)

What gives you most joy or pleasure in your life?

What are your main worries and fears?

What are your most important hopes or dreams?

Please add any other information you would like me to know about you and your situation?